Comments to the Board

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March 20, 2014 Board Meeting

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RAUL RUIZ, MD
36TH DISTRICT, CALIFORNIA

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Congress of the United States
House of Representatives
Washington, DC 20515–0536

January 28, 2014

Peter V. Lee
Executive Director, Covered California
560 J Street, Suite 270
Sacramento, CA 95814

Dear Mr. Lee,

On Thursday, January 23, 2014, I gathered representatives from the organizations housing certified enrollment counselors in my congressional district. The conversation around the table was positive and fruitful. And it remains clear that major gains have been made to maximize enrollments for eligible individuals under the Affordable Care Act. I write to convey to you my strong support for a solution to a concern brought to my attention at this meeting.

Certified enrollment counselors (CEC) in my district are doing a tremendous job identifying the uninsured segment of our population, and conducting direct outreach, eligibility screening, and enrollment. Nearly 10,000 individuals and families have accessed affordable healthcare in my district. But in a geographically large district—such as the one I represent—this outreach and enrollment work most often involves home visits to individuals and families. CECs reported to me that in order to receive clarification or expert assistance with individual applications, they must call the Covered California general customer assistance hotline, which has an average wait time of 49 minutes. One certified enrollment counselor at the January 23 meeting said,

> "If I have a whole day of enrollment, I take whatever [questions] I can't accomplish on my own, compile them, and I wait for first thing the next morning to call [the customer service line] at 7:58AM so I'm first in line when they open at 8:00AM. I'm on the phone with them for 40 minutes with my issues."

As more counselors become certified, and as outreach and enrollment efforts amplify and accelerate, it becomes even more important to provide the necessary support for our certified enrollment counselors. A similar, dedicated "trouble shooting" hotline was created for the successful Healthy Families Program administered by the State of California. A dedicated support team, known as Bridge Line, has already been created by Covered California to help certified enrollment counselors address technical system problems. This same logic should be extended to support on-the-ground certified enrollment counselors. Therefore, I write to strongly advocate and I ask that Covered California staff a dedicated assistance hotline for certified enrollment counselors.

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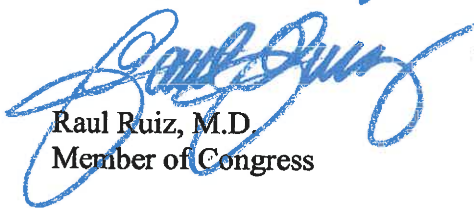
Once again, thank you for the hard work you and your team are doing to ensure that all Californians access affordable, quality health care. Please do not hesitate to contact me or my staff if we can be of any assistance to you.

Sincerely,



Raul Ruiz, M.D.
Member of Congress

February 26, 2014

The Honorable Raul Ruiz
House of Representatives
1319 Longworth HOB
Washington, DC 20515

Dear Congressman Ruiz,

Thank you for your inquiry regarding the establishment of a dedicated assistance hotline for Certified Enrollment Counselors.

We agree on this need, and I am pleased to report to you that a dedicated phone line operation to support our Certified Enrollment Counselors is now operational. This is part of our broader effort to reinforce community based resources that can provide one-on-one assistance.

A dedicated and fully-staffed unit is operating Monday through Friday to take calls and answer questions from our Certified Enrollment Counselors who are enrolling consumers in their communities. The phone number is 1-855-324-3147. A separate dedicated phone is also now serving Certified Agents. The number is 1-855-777-6782.

Again, thank you for your suggestions and leadership on the implementation of the Affordable Care Act.

Sincerely,

Peter V. Lee
Executive Director

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BOARD MEMBERS Diana S. Dooley, Chair Kimberly Belshé Paul Fearer Susan Kennedy Robert Ross, MD **EXEC DIRECTOR** Peter V. Lee

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Congress of the United States
House of Representatives

Washington, DC 20515–0536
January 27, 2014

David Jones
Insurance Commissioner, California Department of Insurance
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Diana Dooley
Secretary, California Health and Human Services
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Sacramento, CA 95814

Peter V. Lee
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Commissioner Jones, Secretary Dooley, and Mr. Lee:

I write to commend the team at Covered California for its success in these early stages of implementing the Affordable Care Act. Many national experts have pointed to Covered California as a model for other state exchanges, and more than a half million Californians now have access to affordable health coverage as a result of the efforts by Covered California.

As a Californian and a physician, I have long been committed to ensuring that every family has access to health care. Now, as a Member of Congress, I want to ensure that every person who enrolls in health plans through Covered California actually receive the coverage they select for the timeframe that is promised.

As has been widely reported, some private insurance companies are still working through a backlog of applications due to "back end" administrative delays.[1] For example, some consumers who applied for coverage to begin on January 1 did not receive confirmation of their coverage or the necessary information to remit their first premium payment to effectuate their health insurance coverage. Long wait times with the Covered California customer service hotline, as well as inadequate communication with consumers' selected insurance providers, further exacerbates the confusion experienced by consumers.[2] I want to prevent a situation where these consumers are retroactively denied coverage because they unintentionally missed their first premium payment deadline. In particular, I want to ensure that health plans do not have the option of refusing coverage because of unintentional delays in premium payments.

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[1] Terhune, Chad. "Anthem Blue Cross, Kaiser Permanente extend payment dealines again." *Los Angeles Times* 14 January 2014 http://www.latimes.com/business/money/la-fi-mo-health-insurance-payment-deadlines-20140114,0,7614652.story#axzz2qgl6uZfN.
[2] *Id.*

I am aware that Covered California has negotiated with private health insurance providers to extend the deadline for consumers' first premium payment to January 15. First premium payment deadlines were further extended by Anthem Blue Cross and Kaiser Permanente to January 22, 2014.[3] These extensions were to accommodate the high volume of backlogged applications, as well as to give time to consumers to remit their first premium. But I believe it is essential that all Californians receive equal treatment, regardless of the plan or insurance company they select. And just as importantly, I believe it is essential to take every possible step to guarantee that nobody enrolled is denied coverage because of confusion about when their first premium payment is due.

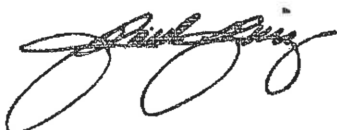
For these reasons, I ask you to exercise your authority to negotiate that insurance providers participating in the Covered California benefits exchange guarantee health care coverage beginning on January 1 for those consumers who properly enrolled by December 23, 2013 and pay their first premium by January 31, 2014. Furthermore, with accelerated and increased enrollment expected for the months of February and March, we ask for one-time grace periods for consumers' first premium payment in each of the months of February and March.

We know that as the Affordable Care Act is implemented, it will need to be modified to better serve the American people. Implementing the provisions proposed above relies on the state certifying these provisions and Covered California negotiating an agreement with individual insurance companies. Given these circumstances, I ask that you negotiate to extend the period for consumers to remit their first premium payments for coverage beginning on the first day of the months of February and March, 2014.

As a Member of Congress from the California Delegation, I encourage you in the strongest terms possible to implement this policy recommendation swiftly to ensure that California families can access the health insurance plans for which they have applied.

Thank you for your immediate attention to this issue.

Sincerely,



Raul Ruiz, M.D.
Member of Congress

CC: Kathleen Sebelius, Secretary, Department of Health and Human Services

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[3] *Id.*

February 26, 2014

The Honorable Raul Ruiz
House of Representatives
1319 Longworth HOB
Washington, DC 20515

Dear Congressman Ruiz,

Secretary Dooley has asked me to provide you with a response to your request to extend the premium payment deadlines for the duration of open enrollment.

Earlier this year Covered California worked with our eleven participating health plans to extend the payment deadlines for coverage that began January 1, 2014. In response to the many transitional and technology related issues that made it more difficult for consumers to enroll and pay for coverage, the payment deadline was extended from January 6 to January 15. Several plans had further extended this deadline to accommodate consumers, giving an ample window to process applications, send out notices, and process transactions.

To date, over 800,000 Californians have enrolled and selected a health plan. Thousands more are signing up each day. Although we are monitoring conditions carefully, we are not proposing to adjust the payment deadlines at this time for the remaining of open enrollment. Both our health plans and consumers benefit when there is a stable marketplace with clear and predictable rules.

Some of our participating health plans have acted on their own to extend payment deadlines to assist the consumers who have enrolled in those plans. For example, for coverage that began on February 1, Blue Shield and HealthNet extended their payment deadline to Jan 31; Kaiser extended their deadline to February 18.

Covered California is committed to the continued improvement of the consumer experience. To ensure smooth enrollment and payment, Covered California has taken steps to help our consumers understand the various health plan deadlines, and provide them with information they will need. We've added an easy-to-find "How to Pay" section on our website containing all the deadlines and contact information for the Exchange's 11 medical and 6 pediatric dental insurance companies, and how to submit payment by phone, mail, or online.

In preparation for the final weeks of enrollment, we have also recently hired 350 Service Center Representatives, and are updating the capacity of our call center phone lines. In

BOARD MEMBERS Diana S. Dooley, Chair Kimberly Belshé Paul Fearer Susan Kennedy Robert Ross, MD EXEC DIRECTOR Peter V. Lee

addition, we are upgrading the capacity of the Covered California website in order to meet the expected increased traffic for the final push. This additional infrastructure will allow consumers to enroll in a plan without delay and ensure payment can be made on time.

Moving forward, Covered California and our participating health plans will continue to communicate with consumers who are still in the process of selecting a plan to ensure that they are aware of the upcoming deadlines for the remaining of open enrollment.

Please let me know if I can be of further assistance.

Sincerely,

Peter V. Lee
Executive Director

cc: Diana S. Dooley, Chair, Covered California Board
Dave Jones, Insurance Commissioner, California Department of Insurance
Kathleen Sebelius, Secretary, Department of Health and Human Services

STATE OF CALIFORNIA Dave Jones, *Insurance Commissioner*

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By electronic transmission

March 18, 2014

Peter V. Lee
Executive Director
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560 J Street, Suite 290
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RE: COMMENTS TO PROPOSED 2015 STANDARD PLAN DESIGNS

Dear Mr. Lee:

Below are our detailed comments on Covered California's proposed 2015 Standard Plan Designs.

The Department of Insurance has a unique perspective to offer Covered California concerning the standard plan designs because of our experience enforcing them in 2014 health insurance policies.

The standard plan designs are significant in many respects, not the least of which is that all health insurers, including those participating only in the individual or small group markets outside the Exchange, must offer standard plans in all four metal levels of coverage. Because of the centrality of the standard plans to California's health insurance market, we hope that Covered California will carefully consider our comments. While we understand Covered California's desire to make minimal changes this year, many of our comments request additional clarification or recommend compliance with existing laws rather than suggesting significant departures from the 2014 plan designs.

In general, it appears that Covered California is moving toward a less detailed standard plan design. In reviewing health insurance policy forms, the Department of Insurance ("Department") relies upon statutory and regulatory requirements. We cannot enforce unstated intentions or even standard conventions. Insurance Code section 10112.3 provides the Department with authority to enforce Covered California's standard plan designs in policies sold inside and outside of the Exchange. However, if the standard plan designs, as currently proposed, become less prescriptive, insurers may very well attempt to interpret them at consumers' expense. In effect, providing less detail will result in less uniform standard plans. Because the proposed 2015 standard plans provide fewer enforceable requirements than the 2014 plans, standard plans will not be as "standard" next year as they are this year if your draft is adopted. This observation, as

well as the Department's mission to protect the health and economic security of consumers, underlies the comments in this letter.

1. ELIMINATION OF THE FOOTNOTES AND "OTHER PRACTITIONER" CATEGORY DECREASES STANDARDIZATION

We would like to express deep concern at the disappearance of the footnotes, as well as the "other practitioner office visit" category. We routinely use the footnotes as interpretive authority and have expended considerable effort enforcing various aspects of footnotes 1 and 5. The "other practitioner office visit" category, the scope of which is established by footnote 5, is a catch-all category for cost sharing applicable to essential health benefits delivered by non-physicians and for which cost sharing is not otherwise specified in the standard plan design, such as acupuncture and health education programs. It is worth noting that "other practitioner office visit" is a category on the Summary of Benefits and Coverage disclosure form and, per federal instructions, applies to acupuncture. Elimination of footnote 5, and elimination of this category, means that there will be no standard cost share for acupuncture and other essential health benefits to which it applies via the rule provided in footnote 5.

Similarly, footnote 1 defines the details of cost sharing in family plans. Without footnote 1, insurers may interpret the separate brand prescription drug deductible in the silver plans as an individual deductible, meaning that <u>each</u> individual enrolled in a family plan will have to meet the deductible before any coverage for brand drugs is provided for that individual. Under the requirement of footnote 1, that "[f]amily deductibles and out-of-pocket maximums are equal to 2 times the individual values," the Department is able to require a family brand prescription drug deductible. If footnote 1 is eliminated, it will become more difficult for regulators to prevent insurers from treating the brand prescription drug deductible as an individual deductible in family plans.

In conclusion, we urge Covered California to reconsider its proposal to eliminate the footnotes and the "other practitioner office visit" category. In contrast to your stated goal to minimize changes in 2015, elimination of these components of the 2014 standard plan design represents a significant change from this year's plan design and will have many unintended negative consequences. It will result in less standardization of cost sharing for essential health benefits and provides fewer enforcement tools, especially with respect to how cost sharing works in family plans. Finally, should you decide not to eliminate the footnotes, we would like to provide technical assistance in revising them for improved clarity. A few of the comments we provided to your plan management staff when we met on the standard plan designs recommended drafting improvements to the footnotes. Suggestions for improvement of the footnotes are included in the attachment to this letter.

2. REDUCE THE EXCESSIVE DEDUCTIBLE IN THE BRONZE PLAN

The Department requests that Covered California reduce the unnecessarily high deductible in the bronze plan, which is offered in both the individual and small group markets. State law provides that the deductible in a small group health insurance policy issued in 2015 shall not exceed $2,050 for an individual policy and $4,100 for a family policy. (California Insurance Code

(CIC) § 10112.29(a).) The bronze plan's deductible, at $5,000 for an individual and $10,000 for a family, is more than twice the legal limit. The actuarial value of the proposed 2015 bronze plan is 60.5%. With a $4,000 deductible, the actuarial value of the bronze plan increases to 61.5%. Therefore, the bronze plan deductible may be lowered by as much as $1,000 while comfortably maintaining the bronze level of coverage (58-62% actuarial value).[1]

In order to approve small group forms containing a deductible that exceeds the limit, the Department must "consider affordability of cost sharing for insureds and ... whether insureds may be deterred from seeking appropriate care because of higher cost sharing." (CIC § 10112.29(a)(4).) A 20%, or even 10%, decrease in the bronze plan's considerable deductible will substantially benefit consumers in these respects, while the Department's actuaries conclude that a one percent increase in actuarial value due to reduction of the deductible will not measurably affect premiums. Consequently, Covered California should lower the bronze plan's deductible —to both comply with the law and do the right thing by California's consumers.

3. CHANGE THE COST SHARE FOR REHABILITATION AND HABILITATION SERVICES IN THE BRONZE PLAN FROM COINSURANCE TO A COPAYMENT

An important feature of the 2014 standard plans is that the copayment for "primary care visit," "other practitioner office visit," "mental/behavioral health outpatient services," "substance use disorder outpatient services," "rehabilitation services," and "habilitation services" are all equal, except in the bronze plan. Equality of cost sharing for these benefit categories is important because of mental health parity law, (CIC § 10112.27(a)(2)(D)), and also because there is significant overlap in the benefits that may fall under the categories. If the cost share is higher for one category, insurers may attempt to exploit the difference to charge more for a particular benefit. For example, we want to avoid a situation in which some insurers attempt to categorize behavioral health therapy for autism in the policy form as a habilitation service rather than a mental health service in order to charge higher cost sharing for the benefit.

One exception to equality of cost sharing in the 2014 and proposed 2015 standard plans is the bronze plan, in which a $60 copayment applies to all aforementioned categories but rehabilitation and habilitation services, which are instead subject to 30% coinsurance. We believe this discrepancy may have been inadvertent. According to our calculations, changing the cost share of rehabilitation and habilitation services to a $60 copayment will have a negligible effect on the actuarial value of the bronze plan (a 0.1% reduction). We therefore recommend changing the cost share for rehabilitation and habilitation services in the bronze plan from 30% coinsurance to a $60 copayment. There are no apparent adverse consequences to making this change, while it will benefit consumers who utilize rehabilitation and habilitation services such as speech, physical, and occupational therapies.

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[1] Actuarial values (AV) for the bronze plan with various deductibles (computed with the 2015 actuarial value calculator) are as follows: 60.5% AV at $5,000; 60.9% AV at $4,500; 61.2% AV at $4,250; 61.5% AV at $4,000; and $62.0% AV at $3,750.

4. REVIEW HIGH DEDUCTIBLE HEALTH PLAN DESIGN TO ENSURE COMPLIANCE WITH FEDERAL TAX LAWS

Covered California must ensure that its plan designs do not disqualify purchasers from making tax preferred contributions to health savings accounts ("HSA"). With the exception of preventive care, federal law provides that "an HDHP [High Deductible Health Plan] may not provide benefits for any year until the minimum deductible for that year is satisfied." (IRS Notice 2013-57 (Sept. 30, 2013).)[2] We have been unable to identify legal authority that would permit the exemption of embedded non-preventive pediatric dental and vision benefits from the deductible in HDHPs. While federal law provides an exception for separate dental and vision insurance, as far as we are aware the question of whether this exception applies to embedded dental and vision benefits is unresolved.

Because there does not appear to be legal authority for exempting embedded non-preventive pediatric dental and vision benefits from the minimum deductible in HDHPs, we are concerned that a separate $0 pediatric dental deductible is impermissible. Given this uncertainty and the tax consequences for consumers and businesses of purchasing a noncompliant HDHP, Covered California should err on the side of caution. Unless Covered California discovers solid legal authority for exempting embedded non-preventive pediatric dental benefits from the deductible in HDHPs, we recommend that Covered California create a separate embedded pediatric dental plan design for HDHPs (and catastrophic plans, see below) that does not include a separate pediatric dental deductible.

Finally, despite the standard plan design, the Department does not require insurers to exempt eyeglasses from the deductible in the SHOP silver HSA plan and the bronze HSA plan. Eyeglasses do not meet the definition of a preventive benefit for purposes of an HDHP because they are "intended to treat an existing illness, injury, or condition." (IRS Notice 2004-23 (April 12, 2004).) Due to the legal uncertainty surrounding this issue, Covered California should consider specifying that the deductible applies to eyeglasses for pediatric enrollees in the SHOP silver HSA plan and the bronze HSA plan.

5. RECOMMENDED CHANGES TO THE STANDARD PLAN DESIGNS FOR CLARITY

Below we identify several modifications that should be made to the proposed 2015 standard plan design to enhance clarity.

A. For the "tests" and "rehabilitation services" and "habilitation services" categories, the standard plan design should specify that the cost share applies when the services are received on an outpatient basis. We understand this was intended, but it should be made explicit.

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[2] The minimum annual deductible for 2014 is "not less than $1,250 for self-only coverage or $2,500 for family coverage." IRS Rev. Proc. 2013-25 (May 20, 2013).

B. In the platinum and gold copayment plans, the cost share for inpatient services is "$250 per day up to 5 days." A footnote should be added to clarify the cost share that applies after 5 days; otherwise, insurers might attempt to specify any cost share they choose if actuarial value is unaffected.

C. For pediatric "eye exam," 0% should be changed to "No cost share" and the notation "deductible waived" should be deleted, as applicability of the deductible is already specified by the "deductible applies" column. According to the federal instructions for Summaries of Benefits and Coverage disclosure forms, "No cost share" is the correct terminology to use when a benefit is not subject to cost sharing or a deductible, while a $0 copayment or 0% coinsurance is the correct cost share to use when the deductible applies.

   Additionally, for "glasses," "1 pair per year" currently appears in the "member cost share" column. This notation should be moved to the "service type" column as a parenthetical and the cost share should be specified as "No cost share" or 0% depending on whether the plan is an HDHP. As explained above, it would also be prudent not to exempt eyeglasses from the deductible in the SHOP silver HSA plan and the bronze HSA plan.

D. For "Drugs to treat illness or condition," the standard plan design should specify the supply of drugs to which the cost share applies (such as "up to a thirty day supply").

E. The standard plan design establishes the cost share for "Drugs to treat illness or condition" by dividing drugs into four tiers: "Generic drugs," "Preferred brand drugs," "Non-preferred brand drugs," and "Specialty drugs." However, these descriptions do not accurately depict how most insurers structure their prescription drug formularies. We understand that insurers generally classify drugs by cost such that some or all of the tiers are mixed as to the types of drugs that are included. For example, higher-cost generic drugs may be classified in both the second and third tier, and some low-cost brand drugs may be classified in the first tier. Furthermore, it is possible that some insurers may classify non-specialty drugs in tier 4 in order to charge coinsurance for those drugs in standard plans.

   It is unclear from the standard plan design whether Covered California intended to standardize the structure of prescription drug formularies, whether Covered California intended only to standardize the names of the tiers themselves, or whether Covered California intended simply to establish cost sharing for the first, second, third, and fourth tiers of an insurer's existing formulary, regardless of the classification of drugs contained therein. For standardization to be meaningful, the plan design must be clear as to precisely what Covered California is standardizing: is it cost sharing for all generic, brand, and specialty drugs regardless of where they appear in an insurer's formulary, or is it cost sharing for each tier regardless of the drugs contained therein?

If Covered California intended to standardize the names of the tiers and the drugs they contain such that all generic drugs must be classified in tier one, insurers would have to create new drug formularies to comply with the standard plan design. Under the structure of insurers' existing formularies, the first tier in standard plans is misleadingly called "Generic drugs" even though some generic drugs are subject to higher brand drug cost sharing. An insured may purchase a generic drug and expect first tier cost sharing, but will not pay that cost share because the drug is actually classified in another tier. Likewise, the label "Generic drugs" implies that insurers may not charge generic drug cost sharing for a non-generic drug.

Covered California should examine its intent regarding this issue and communicate it clearly in the 2015 standard plan designs. If Covered California does not intend to standardize formulary structure in 2015, the Department suggests renaming the drug tiers to "Tier 1," "Tier 2," "Tier 3," and "Specialty drugs *only*," (retaining the footnote pertaining to the limit on cost sharing for oral anti-cancer drugs required by A.B. 219). This change represents a more accurate description of formulary structure, allows insurers to keep using their existing drug formularies, avoids misrepresenting the cost share for generic drugs to consumers, and may prevent insurers from charging specialty drug coinsurance for non-specialty drugs.

6. STANDARDIZE COST SHARING FOR ESSENTIAL HEALTH BENEFITS AND CONSIDER EMPLOYER CONTRIBUTIONS TO HSA COMPATIBLE PLANS

We request that Covered California standardize cost sharing for essential health benefits that are not currently included in the standard plan design in 2015. Essential health benefits for which cost sharing is not specified by the standard plan design include health education programs, pediatric contact lenses, contact lens fitting and follow-up exams, and low vision services and aids, as well as non-surgical services received at outpatient facilities. Currently cost sharing and applicability of the deductible for some pediatric vision essential health benefits, including low vision services and aids, is not uniform in standard plans, which could easily be remedied by adding them to the standard plan design.

As the standard plan design is currently configured, the cost share for non-surgical outpatient services received at outpatient facilities is not standardized. Examples of such services include dialysis, chemotherapy, radiation therapy, drug infusion therapy, and mental health and substance use outpatient facility services. Because these services are not surgical, it is unclear whether the cost share for the "outpatient surgery" category applies; however, this is the only category for outpatient facilities that is currently included in the standard plan design. Covered California should clarify whether the "outpatient surgery" cost share applies only to outpatient surgery, or whether it also applies to non-surgical services received in outpatient facilities. Notably, if the outpatient surgery cost share applies, these services are expensive for consumers who purchase standard plans because they are utilized on a repeated basis.

In designing its 2015 plans, Covered California should also consider the permissible range of employer contributions to its HDHPs. Under state and federal law, employer contributions to a health savings account ("HSA") must be counted toward the actuarial value of an HSA

compatible plan. (CIC § 10112.297(b)(6); 10 CCR 2594.6(e); 45 CFR § 156.135(c).) An employer contribution that is not within a permissible range will drive the plan outside of the actuarial value range for a level of coverage; health insurers are prohibited from selling such plans. (CIC § 10112.3(d).) As an example, the maximum contribution an employer may make to an HSA for an employee enrolled in the 2014 SHOP silver HSA plan, while maintaining the silver level of coverage, is only $26. Although the silver HSA plan is marketed as an HSA compatible plan, an employer may not make a significant contribution to its employees' HSAs. Covered California should rectify this situation.

7. RELEASE FINAL STANDARD PLAN DESIGN WITH SUFFICIENT TIME BEFORE THE BOARD MEETING TO ALLOW FOR MEANINGFUL PUBLIC REVIEW AND COMMENTS

Lastly, we are concerned that the medical and dental plan designs the board is scheduled to approve on March 20 will not be identical to the proposed plan designs released for comment on February 20 and March 7, respectively. Clearly, some modifications to the currently proposed medical plan designs must be made to account for elements of the final *HHS Notice of Benefit and Payment Parameters for 2015* rule. The Department would like to have a meaningful opportunity to comment on the final plan designs before they are adopted. We cannot verify actuarial value, nor verify compliance with other state laws, unless we have the final plan designs before us. Nevertheless, below we offer comments on some aspects of the currently proposed 2015 standard plan designs, as well as the updated dental plan designs.

A. Section 10112.295(c)(1) of the Insurance Code provides that "[a] catastrophic policy is a health insurance policy that provides no benefits for any plan year until the insured has incurred cost-sharing expenses in an amount equal to the annual limit on out-of-pocket costs … except that it shall provide coverage for at least three primary care visits." Therefore, the deductible and out-of-pocket maximum in the 9.5 and 10.0 catastrophic plans must be raised to the maximum out-of-pocket limit for 2015, which is $6,600 for an individual and $13,200 for a family. While we do not take issue with reduction of the out-of-pocket maximum in gold, silver, and bronze plans to allow space for a stand-alone dental plan's out-of-pocket maximum, this approach is inconsistent with state law on catastrophic plans.

   Moreover, Covered California may not exempt non-preventive benefits, except for three non-preventive primary care office visits, from the deductible in catastrophic plans. (CIC § 10112.295(c)(1).) This means that embedded pediatric dental benefits may not be subject to a separate $0 deductible in catastrophic plans. Consequently, we recommend that Covered California create a separate embedded pediatric dental plan design for catastrophic plans (and HDHPs, as explained above) that does not include a separate pediatric dental deductible.

B. The embedded pediatric dental plan, as well as the stand-alone and family dental plans, specify that there may be no "waiting period." The generic term "waiting period" is ambiguous because it could refer to three different types of waiting periods defined in the law: preexisting condition provisions, waivered condition provisions, or "condition of

employment" waiting periods. A preexisting condition provision is "a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage." (CIC § 10198.6(b).) A waivered condition provision is "a contract provision that excludes coverage for charges or expenses incurred during a specified period of time for one or more specific, identified, medical conditions." (CIC § 10198.6(b).) State law already prohibits both preexisting condition provisions and waivered condition provisions in group and non-grandfathered individual health insurance policies. (CIC § 10198.7(a), (b)(1).) Additionally, waiting periods for health insurance are prohibited in the individual market. (CIC § 10198.7(c)(2).) In the group market, a waiting period not exceeding sixty days may be imposed as a condition of employment if it is applied equally to all eligible employees and dependents and is not based on a pre-existing medical condition or other health status-related factor. (CIC § 10198.7(c)(1).)

It may be reasonable to specify by contract that there can be no "waiting period" for pediatric dental essential health benefits covered by stand-alone or family dental plans sold on the Exchange because the policies cover excepted benefits that are not subject to state law on preexisting and waivered condition provisions and waiting periods. (CIC § 10198.6(a).) However, the <u>embedded</u> pediatric dental plan design should not specify that there may be "no waiting period." Health insurers are already prohibited from imposing "waiting periods" based on preexisting medical conditions or from excluding benefits for a specified medical condition for any period of time (preexisting condition provisions and waivered condition provisions, respectively). Thus it is unnecessary for Covered California to prohibit these types of "waiting periods" for embedded pediatric dental essential health benefits.

With respect to "condition of employment" waiting periods, Covered California's embedded pediatric dental plan design should not contradict state law. Imposing a prohibition on "condition of employment" waiting periods in standard small group health insurance policies goes beyond standardizing cost sharing and potentially applies to small group health insurers that do not contract with Covered California; as a result, the effect of such a standardization requirement outside the Exchange would conflict with state law. (CIC § 10198.7(c)(1).) Additionally, a prohibition on condition of employment waiting periods for only pediatric dental essential health benefits covered by a health insurance policy would be difficult to enforce because all of the other benefits covered by the policy may be subjected to a waiting period not exceeding sixty days. Therefore, we ask that Covered California not address "waiting periods" in its embedded pediatric dental plan design.

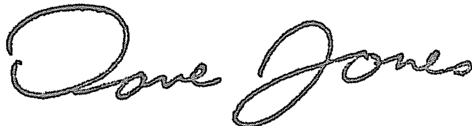
C. Given the different types of "waiting periods" that are defined in the law, Covered California should clarify exactly what types of "waiting periods" it intends to prohibit with respect to the pediatric dental benefit in stand-alone and family dental plans. The family dental plan, which permits a "waiting period" of six months for major services for adult enrollees in the coinsurance plan, suggests that Covered California only intends to

prohibit waivered condition provisions, but we are not certain of the meaning intended by use of the ambiguous term "waiting period." Because of the resulting uncertainty, it will be difficult to achieve consistent, uniform implementation of Covered California's intent unless the ambiguous term is clarified.

D. Finally, actuarial values for two of the proposed 2015 standard plans fall outside of the permissible actuarial value range for the level of coverage of the plan. The actuarial value for the Platinum Coinsurance plan is 87.9% (permissible range 88.0% - 92.0%) and the actuarial value for the Silver 200% - 250% FPL Coinsurance plan is 74.4% (permissible range 72.0% - 74.0%).[3] Because the standard plans are incompatible with the Actuarial Value Calculator, the Department made adjustments to the actuarial value produced by the calculator pursuant to section 156.135(b) of Title 45 of the Code of Federal Regulations. (See also 10 CCR § 2594.6(c).)

In conclusion, thank you for considering the Department's comments to the proposed 2015 standard plan designs. I reiterate that many of our suggestions may easily be accommodated, are consistent with Covered California's stated goal of maintaining consistency with the 2014 plan designs, and would benefit consumers. Though none of these are significant changes, they are important issues to address nonetheless. We look forward to working with Covered California plan management staff to incorporate our recommendations into the proposal that will ultimately be voted on by the board.

Sincerely,



DAVE JONES
Insurance Commissioner

Attachment: Suggested Text for Standard Benefit Plan Design Footnotes

Cc: Leesa Tori, Interim Director, Plan Management
Kathleen Keeshen, General Counsel
John Bertko, Chief Actuary and Director of Research

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[3] The Department calculated these actuarial values based on the following sources: 1) the 2015 Actuarial Value Calculator (final version released on March 6, 2014 in conjunction with the *HHS Notice of Benefit and Payment Parameters for 2015* final rule); and 2) adjustments made to the actuarial value produced by the Actuarial Value Calculator according to the method described in *Actuarial Certification of Standard Plan Design Fit* prepared for the 2014 standard plans by PricewaterhouseCoopers on May 20, 2013. Although this certification should be updated for the 2015 standard plan actuarial value calculations, we believe that the results of the update will be very close to the numbers reported here.

***Complaint* Comment Received via E-mail**

Subject: Covered California's Dishonest Television Advertising

Dear Mr. Lee,

I'm writing to express my frustration with Covered CA's television campaign which features a young woman identified as "Paola." Paola's pitch is to encourage Californians to sign up for health insurance coverage through Covered CA, and she explicitly states that the good news is that "millions of Californians will qualify for financial assistance" to help them pay for the insurance available through the Covered CA Exchange.

As I thought about this, I asked myself, where is this "financial assistance" coming from? Then I realized that since this is a program administered by a state agency, your agency, I realized that the use of the term "financial assistance" is a euphemism for "tax payer assistance" or perhaps better still, "tax payer subsidies." After all, all of the programs of the State of California are financed by taxes of one sort or another on people living and engaging in business in this state. If this is in fact the case, then Paola's calling a "tax payer subsidy" "financial assistance" is disingenuous at best, and borders on dishonesty that would place the "advertisement" squarely in the domain of propaganda. "Financial assistance" makes it sound rather innocuous, almost like a "scholarship" or a "grant" that a student might receive from a foundations when attending college. But if in fact she's really talking about tax payer subsidies, then your agency and Covered CA is doing a disservice to the taxpayers of this State by not forthrightly describing the source of the "financial assistance" Paola is so excited about.

Or perhaps some of the money is coming from the federal government? If that's the case, then not only are California tax payers being hit with the bill, but tax payers in the other 49 states are also picking up part of the tab for these millions of Californians who qualify for what Paola calls "financial assistance." If that's the case, then surely your agency and Covered CA would want to reassure the tax payers in this state that we're not being stuck with the entire bill for this program. Why not have Paola breathlessly exclaim, "And this financial assistance is being provided by people living in Missouri and Maine and Florida and Texas! Aren't they wonderful?"

And so, Mr. Lee, I'd like to know the answers to the following questions:

1. What is the "average" amount of "financial assistance" (i.e., tax payer subsidies) that these millions of Californians are going to receive? Is it $500? $1,000? More?

2. Where exactly is the money to provide this "financial assistance" going to come from?

3. How much is this "financial assistance" going to increase the already burdensome taxes levied on the tax payers in this state?

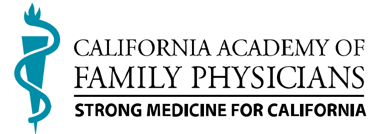
4. Why doesn't Covered CA call the "financial assistance" what it really is, a "tax payer subsidy"?

5. Finally, why is it so difficult to find an email address for you as the Executive Director of the Health Benefits Exchange? I spent over half an hour looking in vain at the Covered CA web site, and the web site for the Health Benefits Exchange. Only when I went to the main page for the State of California and looked under the various agencies and departments did I finally find the "generic"

email address to which I sent this note? Why is it so difficult to track you and the other Board members down in order to send you an email communication?

I look forward to receiving your response. As a tax payer in this State, and therefore someone who pays for your salary and the operating expenses of your agency, I'm confident you will respond in an expeditious manner.

Richard Euson
reuson@roadrunner.com



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www.familydocs.org

March 5, 2014

Mr. Peter Lee
Executive Director
Covered California
Sacramento, CA

Dear Mr. Lee:

The California Academy of Family Physicians (CAFP) submits this letter to raise your and the Covered California Board's awareness of Covered California health plans' contracting strategies, physician responses and the likely impact on access to and quality of health care for consumers purchasing insurance through Covered California.

CAFP, representing more than 8,700 family physicians and medical students in California, is a long-standing advocate for health care reform and Covered California. We are recipients of a Covered California Provider Outreach and Education Grant and have been pleased to provide educational programming on Covered California. In general, our physician members have been highly receptive to this programming; we continually hear them voice their support for increasing the number of insureds in California, as insurance improves health outcomes and quality of life.

With increasing frequency, however, CAFP is approached by physicians with concerns about contracts with Covered California health plans. Physician members describe Covered California health plans reducing rates between 20 and 40 percent and a resulting decision to reject the "Covered California contract" and inability to see "Covered California beneficiaries." Our physicians describe these payment reductions as unaffordable to their practices.

CAFP also is regularly hearing from physician members confused about the status of their contracts, rates and whether they will in fact be paid for health care services provided to "Covered California beneficiaries." We have heard from members who are unable to get answers from the health plans

about their contracts and rates; they describe the health plans' inability to tell them if they are in contract to see beneficiaries newly insured through Covered California plans. The removal of the provider directory from the Covered California website has exacerbated this problem. Physicians are unable to clarify for consumers whether the consumers can see them if they purchase specific plans through Covered California.

Finally, our physician members describe Covered California health plans sending notices that unilaterally amend existing contracts and reduce rates. Our members have, in some cases, missed these notices entirely and only realize there have been significant reductions in rates when they receive payment for services. They contact us concerned about their limited recourse under these circumstances and generally with an interest in rejecting these contract amendments.

Here are some examples from different regions in the state:

- A primary care group in Salinas contacted us with multiple contracting problems with Covered California health plans. One plan refused to provide the rates, prompting the group to terminate the relationship. Another plan reduced rates well below previous rates and Medicare rates. The group reluctantly agreed to the new rates, only to receive payment at even lower rates than those agreed to. After investigation, the group learned that the plan had sent new, vaguely-worded contract language they did not understand that lowered the rates even more. The group was never given the ability to opt out of the new rates, but instead was placed on a panel of physicians accepting the new rates. They are now attempting to opt out.
- A primary care group in Eureka contacted us to describe how they are "not accepting any Covered California," because the health plans are paying them between 20 and 40 percent less than other commercial contracts. The practice described the rates as "incompatible with keeping our doors open."
- A primary care group in in Riverside County contacted us with concerns about CAFP's work "promoting Covered California." The group described 30 to 40 percent reductions in payment rates from Covered California health plans and a decision to opt out. The group described being unable to afford to see "Covered California beneficiaries" at those rates.
- A primary care group in San Jose contacted us to describe a 30 percent reduction in rates by an exchange plan. The physicians in the group felt strongly that they should see the newly insured but equally strongly that the practice could not afford the reduction. They are consulting an attorney to see what their legal options are under their contract and whether they could somehow limit the percent of Covered California consumers on their panels.

These are a few examples among many and CAFP is frustrated by our limited ability to help these practices. We are educating our members that Covered California is not a public benefit program, but an exchange that offers the health plan products of private, commercial payers. We emphasize that physicians must negotiate contracts with these private payers just as they have historically, and to pay careful attention to the provisions of the contracts.

CAFP and the Covered California Board would be remiss, however, if we ignored the likely effect of such contracting strategies on Covered California and consumers purchasing its health plans. We have never received such an outpouring of complaints about plans' contracting strategies and it is clear that physicians are developing the view that Covered California health plans are on a different, lower-paying tier from other private health plans. We have been asked on multiple occasions if medical groups can offer services to the "regular beneficiaries" of a health plan and NOT the "Covered California beneficiaries." We fear that the result of these contracting strategies is that Covered California consumers will be unable to access needed health care services.

Covered California's struggle to develop a functional provider directory exacerbates these problems. We appreciate the inherent difficulty in building a functional directory, especially in a period of great fluctuation in contracts, but we urge you to make the availability of an accurate provider directory a priority. Consumers choose health plans based on the providers that will be available to them. A significant number of California consumers were directed to the Covered California site after losing policies that did not comply with the health care reform law. For these consumers, continuity of care or being able to see historically-used providers may be of the utmost importance to their health. Millions of Californians seeking information and considering their insurance options during this first open-enrollment period do not have accurate information about the health care services they can access.

It is worth noting that providers were using the directory as a starting point in understanding their relationships with Covered California plans. The directory allowed physicians to see whether the health plans claimed them as part of their networks. It was an entry point to a conversation about their contract with the plan and whether they should see the new beneficiaries. CAFP is encouraging our member physicians to verify participation status with the health plans themselves, but as described above this can be a frustrating process.

It appears that Covered California is now leading consumers to each health plan's website directory. This is an inadequate solution. The inaccuracies in the Covered California directory undoubtedly reflect the inaccuracies inherent in the plans' directories and underscore an important problem for Covered California to solve: Covered California consumers should have accurate information about what they are purchasing and they should be purchasing plans with robust networks.

CAFP knows that Covered California is strongly interested in ensuring those robust networks and vetted health plans, in part, based on their claims about their networks. We know that Covered California is promoting enrollment based on those claims (*e.g.*, a December 11, 2013 press release in which Covered California claimed that enrollees can choose from more than 80 percent of California physicians). These networks are threatened as health plans engage in the contracting strategies described above; we urge Covered California to respond: Act now to protect California's consumers and their access to care.

CAFP requests a meeting with the Medical Director or other appropriate person at Covered California to discuss these issues further. We would appreciate your contacting CAFP's Vice President of Health Policy, Leah Newkirk, at lnewkirk@familydocs.org or 415.345.8667 to schedule such a meeting. We also request that the health plans' contracting strategies and the provider directory be discussion items at a

future Covered California Board meeting. Finally, we ask that Covered California establish a hotline for physicians and other providers to raise these kinds of concerns directly with Covered California staff.

We appreciate the opportunity to voice these concerns. We remain dedicated to ensuring the success of Covered California, in part through the provider education and outreach work that we are doing, but also through our role as advocates for family physicians and their patients in the state. We appreciate the great work that you have done in a very short time frame and the success – indicated by high enrollment numbers – of your efforts. As family physicians, we will continue to champion the health and well-being of our patients as they become purchasers through Covered California and we appreciate your attention to our concerns. Please contact Leah Newkirk at lnewkirk@familydocs.org or 415.345.8667 with any questions.

Sincerely,

Mark Dressner, MD

President

cc: Ms. Kimberly Belshé

Ms. Diana S. Dooley

Mr. Paul Fearer

Ms. Susan Kennedy

Dr. Robert Ross

Dr. Jeffrey Rideout

California Family
Resource Association

Strong Families. Strong Communities.

February 26, 2014

Covered California Board of Directors
560 J Street, Suite 290
Sacramento, CA 95814

RE: Outreach & Education Grant Program Leads

Dear Covered California Board Members:

California Family Resource Association (CFRA) appreciates this opportunity to follow up on the comments we shared at the February 20th Board meeting. We want to acknowledge and thank the Board for its longstanding commitment to addressing stakeholder questions and concerns throughout the process of implementing California's new health insurance marketplace.

CFRA is a statewide association representing approximately 300 community-based Family Resource Centers serving California's diverse communities. 30 of our Family Resource Center (FRC) members currently participate as CFRA's sub-grantees in the Covered California Outreach & Education Grant Program.

In the six months since our FRC partners began educating their communities about Covered California they have reached over 30,000 consumers and have submitted nearly 2,000 leads to Covered California. Tens of thousands more leads have been submitted by the other Outreach & Education grantees, totaling as many as 100,000 leads seeking enrollment assistance through this program.

Recently we were notified that most of the leads submitted by grantees to date have not been contacted or provided enrollment assistance. In addition, we are told that there is currently no plan or system in place to enable any follow-up calls to those leads. We are very concerned that the consumers who submitted their contact information as leads to Covered California are under the assumption that they have done all they need to do to initiate the enrollment process and are now waiting for the call from Covered California. We have also heard that some consumers are confused and upset that Covered California has not followed through on its promise to contact and assist them.

It is disheartening for grantees to know that the leads they have worked diligently for months to collect are being neglected at the present time. In a matter of weeks, many consumers may realize too late that open enrollment has ended and Covered California failed to follow up with them in time to avoid a tax

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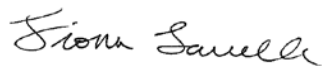
penalty and/or that they may have to wait an additional six months to enroll in the health coverage they need.

Family Resource Centers lent their trusted names and reputations to this program and now some are facing backlash in their communities where consumers are still waiting for the help that was promised to them up to six months ago. We are concerned that this situation could jeopardize the level of trust consumers feel toward our FRC partners, and unfortunately this could negatively impact their ability to reach and deliver services to these consumers in the future.

We strongly urge the Covered California Board to take immediate steps to ensure that leads are contacted by phone and offered enrollment assistance before the open enrollment period elapses. The most expeditious option appears to be increasing call center capacity to contact leads and refer them to enrollment entities in their local area. Other options include disseminating existing leads to grantees and enrollment entities already trained to assist them.

For thousands of consumers still awaiting assistance, addressing this issue will make or break their willingness to trust and engage with Covered California. Following through with these consumers may also save many from unnecessarily paying a tax penalty or delaying access to the coverage and services they need. We look forward to hearing from you regarding how this issue will be addressed. Thank you for attention to this request.

Sincerely,



Fiona Lavelle
Program Manager, California Family Resource Association